UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

LOIS KAMINSKI, individually
and as Administratrix of the
Estate of JAMES F. FITZGERALD,
deceased,

Plaintiff,

vs.

Index No.:
2013-4916

UNITED STATES OF AMERICA, by and
through its officers, agents and/or
employees; JOSEPH P. MARKHAM, M.D.,
individually and as an officer,
agent and/or employee of ST. JOSEPH'S
HOSPITAL HEALTH CENTER; ST. JOSEPH'S
HOSPITAL HEALTH CENTER, by and through
its officers, agents and/or employees;
JOHN H. SUN, D.O., individually and as
an officer, agent and/or employee of
ASSOCIATED GASTROENTEROLOGISTS OF CNY,
P.C.; ASSOCIATED GASTROENTEROLOGISTS
OF CNY, P.C., by and through its
officers, agents and/or employees,

Defendants.

Examination Before Trial of **JOSEPH P. MARKHAM, M.D.**, held on March 15, 2016 at the Law Offices of MacKenzie Hughes, LLP, 101 South Salina Street, Syracuse, New York, before Annette S. Potter, Court Reporter and Notary Public in and for the State of New York.

A P P E A R A N C E S

FOR PLAINTIFF:	BOTTAR LEONE, PLLC Attorneys at Law AXA Tower II, Suite 1600 120 Madison Street Syracuse, New York 13202 BY: MICHAEL A. BOTTAR, ESQ.
FOR DEFENDANT: (United States)	U.S. ATTORNEY'S OFFICE Federal Building, Room 900 100 South Clinton Street P.O. Box 7198 Syracuse, New York 13261-7198 BY: MARY E. LANGAN, ESQ.
FOR DEFENDANT: (St. Joseph's)	HANCOCK ESTABROOK, LLP Attorneys at Law AXA Tower I, Suite 1500 100 Madison Street Syracuse, New York 1 3202 BY: ASHLEY D. HAYES, ESQ.
FOR DEFENDANT: (Dr. Markham)	MACKENZIE HUGHES, LLP Attorneys at Law 101 South Salina Street Suite 600 Syracuse, New York 13202 BY: JENNIFER P. WILLIAMS, ESQ.
FOR DEFENDANTS: (Dr. Sun and Gastro of CNY)	MARTIN, GANOTIS, BROWN, MOULD & CURRIE, PC Attorneys at Law 5790 Widewaters Parkway Dewitt, New York 13214 BY: DANIEL P. LARABY, ESQ.

FEDERAL STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and among the attorneys for the respective parties that the presence of the Referee be waived;

IT IS FURTHER STIPULATED AND AGREED that the witness is to read and sign the transcript, certifying it as to its accuracy and that the filing of the original of this deposition is waived;

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to form, are reserved until the time of trial;

IT IS FURTHER STIPULATED AND AGREED that this Deposition may be utilized for all purposes as provided by the Federal Rules of Civil Procedure;

AND FURTHER STIPULATED AND AGREED that all rights provided to all parties by the Federal Rules of Civil Procedure shall not be deemed waived and the appropriate sections of the Federal Rules of Civil Procedure shall be controlling with respect thereto.

I N D E X O F T E S T I M O N Y

I N D E X O F E X H I B I T S

(Whereupon, JOSEPH P. MARKHAM, M.D., called as a witness, having been duly sworn, testifies as follows:)

(Whereupon, Exhibit No. 1 and 2 were marked for identification, 3/15/16.)

EXAMINATION BY
MR. BOTTAR:

Q Good morning, Doctor. We met briefly off the record. My name is Mike Bottar. I represent the patient and the patient's estate. Today I'm here to ask you some questions. Hopefully you can answer some or most of them for me. If you don't understand me, would you please tell me?

A Yes.

Q If you answer a question as I've asked it, I'm going to assume that you've understood it. Fair enough?

A Yes.

Q If you need a break at any time, that's fine with me. I'd ask that if I have a question pending, you answer my question and then take your break, okay?

A Yes.

Q Today is open book, so to speak, so you should feel free at any point to refer to the records we have here or to something else, if you think you need it, just tell us, okay?

A Yes, thank you.

MS. WILLIAMS: Off the record.

(Whereupon, a discussion was held off the record.)

BY MR. BOTTAR: (Cont.)

Q And finally, please use yes, no, whatever the answer to the question may be, instead of uh-huhs and head nods, so that the court reporter can take down your testimony, all right? She's the second most important person here.

A Yes.

Q I marked as Exhibit 2 what I believe is a copy of your CV. Generally, is your CV current, so to speak?

A I believe it is.

Q When do you think you last put information into that CV, by sort of year reference?

A Probably within a -- one to two years.

Q Anything significant in terms of your experience from your perspective that's not recorded

on your CV, titles, positions, anything like that?

A I don't believe so. I think I have it all listed, to my knowledge.

Q And with respect to the print materials, your publications, or poster presentations, are they all on there, as far as you know?

A Yes.

Q Thank you for bringing that. That will save us a good chunk of time, so I'll move on, okay? I didn't see, and maybe I just overlooked it, have you ever held a formal faculty position?

A Yes.

Q Where was that and when?

A SUNY Upstate.

Q When did you first hold a formal faculty position?

A 1993.

Q And do you hold a formal faculty position at SUNY Upstate today?

A I'm not sure.

Q Fair enough.

A I left to go to St. Joe's, and I think it was continued, but I'm not sure.

Q In your capacity as a formal teaching

position at SUNY Upstate, did you teach students?

A Yes.

Q Were they residents, fellows? You tell me.

A Medical students are different than residents and fellows --

Q Correct.

A -- so all of the above.

Q All of the above, all right. At all stages of education?

A Yes.

Q At SUNY Upstate, did you teach any mid-level or extender providers?

A I know I worked with them. I don't know if I taught students at that stage. I have since, but I don't know if I did at Upstate.

Q Do you teach in some capacity at St. Joe's?

A Yes.

Q Formal classroom, didactic training, on the job? You tell me.

A All of the above.

Q What do you teach in terms of the type of providers at St. Joe's?

A Medical students, dental students, family medicine residents, emergency medicine residents, PA students, nurse practitioner students, nurses, paramedics, EMTs.

Q At St. Joe's, do you have a class with a title that you teach?

A Not as -- no, not a continuing class, no.

Q When you teach at St. Joe's, sort of what intervals do you do that, where and when, how often?

A I do bedside clinical teaching every day and class lectures ad hoc every few months.

Q You are licensed to practice medicine by the State of New York?

A Yes.

Q You were first licensed in 1993?

A Yes.

Q Have you been licensed continuously since 1993?

A Yes.

Q Any limitations, suspension, condition, revocation of your license?

A No.

Q Have you ever been licensed to practice medicine by any other states?

A Yes.
Q Where was that?
A Illinois.
Q When was that?
A It would have been '92 to '93. '92 and '93, I believe.
Q Is your Illinois license current today?
A No.
Q Is it what they call inactive?
A Yes.
Q When it was current or active, were there ever any limitations, suspension, condition, or revocation?
A No.
Q Other than New York and Illinois, any other states?
A No.
Q You have hospital privileges where today?
A St. Joseph's Hospital, University Hospital, and I believe Community Hospital University.
Q For each of those institutions, are they what are called full privileges?
A Yes.

Q Do you hold courtesy privileges at any other institutions today?

A Not that I'm aware of.

Q In 2012, did you hold full privileges at Community, University, and St. Joe's?

A Yes.

Q Did you hold courtesy privileges anywhere in 2012?

A Not that I'm aware of.

Q For anywhere in the world that you have held hospital privileges, have they ever been limited, suspended, conditioned, or revoked?

A No.

Q Have you ever been deposed before?

A Yes.

Q More than once?

A Yes.

Q In one instance was it the Wicks matter?

A Yes.

Q Other than the Wicks matter, what other occasion?

A I don't recall the specific names of the cases, but they were as expert witnesses.

Q In the State of New York, around the

country? You tell me.

A New York State.

Q Other than Wicks, have you ever given deposition testimony as a defendant?

A No.

Q Are you a member of any professional medical organizations?

A Yes.

Q Give me an idea of what and when you started.

A ACEP, which is American College of Emergency Physicians. I believe I started that in 1993, roughly. ABEM, American Board of Emergency Medicine, and I started when I was board certified in '94, I believe.

Q Let me stop you there. I apologize for the interruption. With your board certifications, is it one that requires recertification at certain intervals of time?

A Yes.

Q Is it every ten years --

A Yes.

Q -- two years, ten years?

A Ten years.

Q Have you certified every ten years?

A Yes.

Q When are you next due to recertify?

A 2014. No, I'm sorry, 2024.

Q Approximations are fine.

A 2014 is the last time I certified.

Q Your board certification or recertification, is it one that you could take on an annual basis if you chose to?

A I don't know.

Q Fair enough. I only want to know what you know. You were first board certified, I think you said, in '93 or '96, somewhere --

A 1994. I believe in the '90s.

Q Have you been board certified since you were first certified?

A Yes.

Q Within your board, do you hold any sub-certifications or subspecialities?

A No.

Q If I can flip this around, it's your CV, on the first page at the bottom, are these the professional medical organizations that you have participated in or participate in?

A Yes.

Q Okay, perfect.

MS. WILLIAMS: Just so the record is clearer, looking at the last paragraph of the first page of Exhibit 2.

Q It starts Fellow of the American College and it ends with the American Medical Association. Sir, within any of the professional medical organizations, have you ever held a leadership position?

A Yes.

Q In the leadership position or positions you've held, did you apply for that, were you invited? You tell me.

A Both.

Q Fair enough. Which were you invited to participate or hold?

A I started as Assistant Medical Director at St. Joseph's, and when I became the Director, I'm not -- I don't recall if I was invited or applied for it. Maybe both.

Q How long were you in the Director position at St. Joe's?

A Four years.

Q When to when?

A I believe it was 1999 to 19 -- or 2003. Four years.

Q Director of what, emergency medicine, medical affairs?

A Medical Director of the Emergency Department.

Q Have you ever served in a quality assurance or peer review capacity at any hospital?

A Yes.

Q Has it ever been at St. Joe's?

A Yes.

Q Give me an idea of what you do to stay current in your field.

A I frequently will reference materials while I'm working clinically, and I go to CME evaluations -- or CME courses, and I do CME online. CME meaning Continuing Medical Education.

Q For the CME conferences or seminars, do you tend to go to those put on by a particular provider, one versus another?

A Most of the CME I go to have been courses organized by American College of Emergency Physicians.

Q When did you last go to a conference put on by American College of Emergency Physicians?

A 2014.

Q Did it address particular topics, a set of topics? You tell me.

A It was a board review course.

Q Were there print materials as part of that conference?

A Yes.

Q Was it a -- sometimes they call it a compendium of sorts?

A Yes, a big notebook with additional handouts.

Q Did you review that notebook and handouts as part of your preparation for recertification in 2014?

A Most of it.

Q You mentioned clinical materials. What do you look at to stay current in the context of clinical materials?

A We have online resources in the hospital. UpToDate is the name of the review that we often use in the Emergency Department.

Q For UpToDate, do you have your own login

ID and password?

A Yes.

Q What I'm trying to determine is if it's yours versus the hospital's, if you know?

A I don't know. I go to the web page and click on UpToDate and --

Q And it works.

A I'm signed onto the computer when I get there, so I --

Q Why do you go to UpToDate from time to time when you have questions in clinical practice?

A It's a good general reference. It gives us ideas of things to think about.

Q Are the medical articles or resources available through UpToDate peer reviewed?

A I believe they are.

Q And UpToDate, oftentimes the articles have footnotes with references to research materials; is that correct?

A I believe there is a reference list with every article, yes.

Q When you review materials on UpToDate, do you ever refer to the references and read those materials as well?

A No.

Q When you review electronic materials on UpToDate, do you have a custom and practice to print the materials and keep them somewhere?

A No.

Q Other than UpToDate, what other materials do you review to stay current in your clinical practice?

A I'll occasionally look at an emergency medicine textbook. Tintinalli is a common one.

Q Any others, other than Tintinalli?

A As far as textbooks or references?

Q As far as textbooks.

A That's the most common.

Q Why do you refer to Tintinalli when you do?

A It's a good general reference. Usually I'll refer to it when I'm preparing a lecture.

Q Have you ever taught medical students from the Tintinalli text?

A I'm not sure how to answer that, but I've used that as a reference to put the lecture together.

Q Were you trained in whole or part on the

Tintinalli text?

A We used that as a reference during my training, yes.

Q Do you refer to any other print materials as one way to stay current in your field? By way of example, any journal articles?

A On occasion.

Q When you do refer to journals, what journals do you refer to?

A Oh, I've looked at the Emergency Medicine Journal, occasionally New England Journal of Medicine. I've reviewed some AMA articles.

Q Is the Emergency Medicine Journal the one published by your board, who publishes the Emergency Medicine Journal?

A Right now, I'm not sure if it's ACEP or ABEM. I'd have to look at it.

Q Fair enough. When you refer to that journal, do you have a custom and practice for how you review it, mechanically, cover to cover, particular articles? You tell me.

A Most of my review nowadays is scanning for specific information, so I don't generally do cover to cover.

Q Is the Emergency Medicine Journal peer reviewed?

A Yes.

Q What does peer review mean to you?

A Other experts in emergency medicine have reviewed it to fact check information.

Q Have you ever served on a journal editorial board?

A No.

Q Have you ever served in an editor or editorial capacity for a medicine textbook?

A No.

Q Why do you from time to time refer to the New England Journal of Medicine as one way to stay current in your field?

A It's usually an article that's been referenced by somebody. Residents always challenge us.

Q Like it or not, right?

A Keep us up to date. And sometimes they'll even give me an article.

Q You know the New England Journal of Medicine to be peer reviewed?

A Yes.

Q The AMA journal, do you know what it's called?

A Isn't it AMA?

Q Not super important, I just don't want to put words in your mouth.

A I think so.

Q Let me try this. The journal published by AMA, is it peer reviewed?

A I believe so, yes.

Q Why do you refer to that journal from time to time as one way to stay current in your field?

A Same reason, using articles referenced. I check it out.

Q Do you ever refer to print materials published by the American Heart Association as one way to stay current in your field?

A Occasionally.

Q Does your discipline or specialty or board, so to speak, produce something called Clinical Practice Guidelines?

A Yes.

Q Are they published at certain intervals?

A I don't know when they're published.

Q When they are published, is it your custom

and practice to review the Clinical Practice Guidelines?

A Not just because it's published. I use them as a reference. I will look at the Clinical Practice Guidelines for a particular reason. Again, putting together a lecture often.

Q Do you believe that Clinical Practice Guidelines are an authority relevant to your practice?

MS. WILLIAMS: Objection. Go ahead and answer.

A I don't think anything in writing is an authority. It's information to be used by a clinician.

Q What did you review to prepare for your deposition today, if anything?

A Medical record.

Q I've marked that as Exhibit 1. You, I assume, looked at a different copy, because I brought Exhibit 1 with me.

A Uh-huh.

Q Generally is whatever you reviewed, does it appear to be what I marked as Exhibit 1?

A It appears to be, at initial glance.

Q If during your deposition you believe that we don't have a piece of paper, please let me know, okay?

A Yes.

Q We'll try to track that down. Other than the patient's medical record from St. Joe's, which I've marked as Exhibit 1, did you review any other records for this patient to prepare for today?

A No.

Q By way of example, death certificate, autopsy, anything like that?

A Oh, yes, that was in the paperwork that I was given.

Q I just --

A I did look at the death certificate.

Q And I want to be careful so that I don't get into an area with any information about your attorney, okay? You reviewed the death certificate to prepare for your deposition today?

A Yes.

Q Did you review the cause of death portion?

A Yes.

Q Was there writing or text in the cause of death portion of the death certificate that you

reviewed?

A Yes.

Q Other than the death certificate and the chart marked as Exhibit 1, did you review any other records for the patient to prepare for today?

MS. WILLIAMS: Object to the form of the question. Off the record.

(Whereupon, a discussion was held off the record.)

BY MR. BOTTAR: (Cont.)

Q Can you approximate for me how much time you spent reviewing medical records to prepare for your deposition today?

A Half an hour to an hour.

Q Are there any records for this patient that you would like to review before we proceed with your deposition?

A No, I don't believe so.

Q Anything occurs to you, just stop me and let me know, okay?

A Yes.

Q Who was your employer in February of 2012?

A TeamHealth.

Q Other than TeamHealth, did you have any

other employers in 2012?

A Don't know if I did any 1090 work or not.

Q How about that. How long have you been employed by TeamHealth?

A Since January 2010.

Q Through your training and experience, have you become familiar with signs and symptoms of myocardial ischemia?

A Yes.

Q Can there be more than one sign or symptom of myocardial ischemia?

A Yes.

Q Give me an example of one symptom of myocardial ischemia.

A Chest pain.

Q Are you aware of any other symptoms of myocardial ischemia?

A Yes.

Q I can ask or you can list, however is fastest. Can you give me all of them that you can think of now?

A Yes. So if you have chest pain, shortness of breath, generalized symptoms, nausea, sweating. There can be chest burning. There can be just

generalized fatigue, weakness. I've seen patients with almost any complaint that has myocardial infarction for ischemia that it's hard to tell whether they're related or not, but the most common complaints I've mentioned.

Q You should assume from my questions today that they all refer to men, not women, as I understand women can present differently.

A Well, men and women, the majority of the time, have the similar symptoms, but women tend to have separate symptoms sometimes, as men sometimes also have separate symptoms.

Q You mentioned shortness of breath. Can difficulty breathing be a sign or symptom of myocardial ischemia?

A Yes.

Q Do you differentiate signs and symptoms of myocardial ischemia from coronary artery disease?

A Yes.

Q Are you familiar with signs and symptoms of coronary artery disease?

A Well, that's a complicated answer.

Q Okay. Why is that?

A Coronary artery disease is a process. It

may not have any signs or symptoms. So if they have signs or symptoms, it could be secondary to coronary artery disease, but you can have coronary artery disease without any signs or symptoms.

Q Fair enough. Let me fix my question. Are you familiar with signs or symptoms of symptomatic coronary artery disease?

A Yes.

Q Can you tell me what they are?

A Sometimes it's a chest pain or shortness of breath. It could be fatigue. It could be exertional angina or chest pain with exertion. It could be shortness of breath with exertion. It can lead to congestive heart failure even, if it affects the cardiac output. Weakness.

Q Nausea?

A Nausea, sweating, sympathetic symptoms.

Q Can lightheadedness be a sign or symptom of symptomatic coronary artery disease?

A It could be, yes.

Q Can lightheadedness be a sign or symptom of myocardial ischemia?

A Yes, it could be.

Q Were you working on February 6th, 2012?

A Yes, I was.

Q Either from your memory or your review of records to prepare for today, do you know what day of the week February 6th, 2012 was?

A I do not.

Q Please assume that it was a Monday.

A Okay.

Q Was it customary for you to work particular days of the week at St. Joe's in February of 2012?

A No.

Q Tell me sort of the hours you worked at St. Joe's in February of 2012, shifts, days of the week, whatever you remember.

A I don't remember my specific schedule, but our schedules varied. We worked days, evenings, and night shifts rotating. No particular pattern.

Q In 2012, so a broad question, did you have average number of hours a week -- number of hours you worked a week in the Emergency Department in Central New York?

A I'm sure I did.

Q Can you give me an idea, 40, 50, 60? You tell me.

A Probably 30 to 40.

Q In 2012, were the hours all at St. Joe's --

A Yes.

Q -- at more than one -- yes, okay. Generally, I know we're going back a bit in time, how would you know when you were scheduled to work in February of 2012? By way of example, was it a calendar, something like that?

A We have an online schedule.

Q In February of 2012, did you take call?

A No. We didn't have call.

Q Okay. Do you have a memory of the patient census at St. Joe's in the ED on February 6th, 2012?

A No.

Q Either from your memory or your review of records to prepare for today, have you identified the time that you were first bedside with Mr. Fitzgerald on February 6th?

A I need to refer to the record, this one. It appears approximately 12:40.

Q Help those far away at this table follow along with what page you're looking at. Can you reference in the top right-hand corner of the

document you're looking at in Exhibit 1?

A Page 1 of 9.

Q Is there a particular point or section on that page that tells you when you were first bedside with Mr. Fitzgerald?

A Vital signs, alert reviewed. It has my name and then 12:40. So that would be what I do just as I'm heading in to see the patient.

Q When did Mr. Fitzgerald first present to St. Joe's on February 6th?

A According to the facesheet, the first page in Exhibit 1, he was signed in at 12:01 p.m. in the afternoon.

Q How did he present or arrive to St. Joe's on February 6th, how did he get there?

A I don't know.

Q Please review Page 1 of 9 contained within Exhibit 1.

A Okay. Arrival mode, the patient was brought into the ED on a stretcher. Transport mode, ambulance.

Q Can the manner in which a patient is transported to the Emergency Department be a finding of usefulness to treatment?

A Not necessarily.

Q Does it mean anything to you as a provider one way or the other whether a patient walks in versus they're brought in by ambulance, generally?

A No.

Q Before you were first bedside with Mr. Fitzgerald at around 12:40, did you review any of the hospital record for the treatment he received between approximately noon and when you saw him at 12:40?

A I don't recall.

Q Was it your custom and practice at the time to review the patient's hospital record in the ED, to the extent it existed, before you were first bedside with a patient?

A Yes.

Q Would you customarily review nursing notes?

A Yes.

Q If there was an ambulance run sheet in the record, would it be your custom and practice to review that as well?

A Yes.

Q Why customarily would you review nursing

notes before first providing care and treatment to a patient in the Emergency Department?

A It gives me an idea of why the patient is there and begins my thought process of the care necessary.

Q Why customarily would you review an ambulance run sheet, to the extent it existed?

A To see if there's any pertinent information from the EMS where the -- and to find out where the patient came from, home or someplace else.

Q Either from your memory or review of records to prepare for today, can you tell me whether there were nursing entries in the ED record for Mr. Fitzgerald before you were first bedside?

A There's a triage note here, which is before I was -- before 12:40.

Q Let me sort of try to short circuit this, so I don't keep you here all day. Are there vital signs in the ED record before you were first bedside?

A Yes.

Q Does there appear to be an assessment of systems in the record before you were first bedside?

MS. WILLIAMS: Objection. Go ahead and answer.

A Yes.

Q Does it appear that a healthcare provider interacted face-to-face with Mr. Fitzgerald before you were first bedside?

A Yes. Healthcare provider meaning a nurse?

Q Yes, sir. Do you have a memory of reviewing the entries generated in the hospital record before you were first bedside at or about the time you first treated Mr. Fitzgerald on the 6th?

A No, I have no recollection of this interaction.

Q Would it have been your custom and practice to review the record, and specifically the family history portion of the record, before you first provided care and treatment to a patient in the Emergency Department?

A Yes.

Q Why is that?

MS. WILLIAMS: Objection. Go ahead and answer.

A To get information about the patient.

Q How can family history be -- withdrawn.

Can family history be an important piece of information to diagnosis and treatment?

A Yes.

Q Can it inform a practitioner's risk assessment for a patient?

A Yes.

Q Did Mr. Fitzgerald have any family history recorded in the record that was pertinent to risk assessment for cardiac disease?

A Yes. I believe there's past medical history documented here before I saw him -- or I should say before 12:40.

Q Fair enough. What was entered in the record at around 12:33 with regard to family history next to cancer column?

A Where do you see that?

Q Sure.

A Family history: Cancer, heart disease, father died at age 29 of MI.

Q Were you aware of that information before you first provided care and treatment to Mr. Fitzgerald on February 6th?

A I don't recall that, but I would have looked at this.

Q It would have been your custom and practice to review the information next to this field, correct?

A Yes.

Q Can family history of heart disease increase a patient's risk factor for heart disease?

A Yes.

Q When you first saw Mr. Fitzgerald on February 6th, were you aware of his age?

A It was in the medical record, so I would have, yes.

Q Is that something you generally take note of?

A Yes.

Q You knew that day that he was 39 years old?

A Yes.

Q What was his chief complaint to you?

A Patient presents with complaint of chest pain.

Q Are you referring to the History of Present Illness section on Page 3 of 9 of Exhibit 1?

A I am.

Q Do you have a memory of speaking with

Mr. Fitzgerald when you were first bedside at around 12:40 on February 6th?

A No, I don't recall that interaction. Can I make a correction here?

Q Sure, please do.

A My HPI was noted to have been done at 12:38, so I would have actually seen him before 12:38 long enough to get this history and then sit down and type this, so 12:40 was probably not accurate.

Q Fair enough.

A I had to have seen him before that to get this record.

MR. BOTTAR: Can we go off?

MS. WILLIAMS: Sure.

(Whereupon, a discussion was held off the record.)

BY MR. BOTTAR: (Cont.)

Q Doctor, I directed your attention to a timestamp next to your name at 12:13, does that mean anything to you?

A Yes. That's probably the actual -- accurate time that I first saw the patient.

Q Based on either your memory or the notes

you have, can you approximate how much time you spent with Mr. Fitzgerald when you were first bedside on the 6th?

A Based on the medical record, if I first went to see him at 12:13 and I documented my HPI note at 12:38, that time would have been spent with him.

Q Through your training and experience, have you become familiar with the use of quotations in a patient's medical record, quotes around words?

A Yes.

Q What do quotes around words mean to you, generally?

A Somebody wants you to see that.

Q Have you ever used quotes around words or phrases when you are attempting to quote the patient?

A Yes.

Q When you were first bedside with Mr. Fitzgerald on February 6th, did he use the words chest pain?

A I don't recall what he actually said to me. I can only refer to the medical record.

Q When he -- withdrawn. When you were first

bedside with Mr. Fitzgerald, did he make any gestures with his hands with regard to what he was describing the sensation to be?

A I don't recall that interaction.

Q Have you ever provided care or treatment to patients complaining of chest pain and seen them use their hand in some fashion to describe the location and nature of the pain?

A Yes.

Q Have you ever seen them use a finger to point where the pain is located?

A Yes.

Q Have you ever seen them use a fist or a palm to point to the location of the pain?

A Yes.

Q Does the digit or the way the hand is used mean anything to you as a provider?

A I take note of it.

Q And why is that?

A Just I generally observe the patient's behavior.

Q Is there any information in the record with regard to whether Mr. Fitzgerald was pointing or using a fist or a palm of his hand to describe

the sensation when you were first bedside?

A I need to review the record here.

Q Please do.

A I don't see a reference in the HPI to any particular hand pattern.

Q Are you familiar with medical literature that speaks to when a patient points, it tends to not be cardiac origin pain, or when they use a fist or a palm, it tends to be cardiac origin pain?

MS. WILLIAMS: Objection to form.

A I'm not aware of that.

Q Did you ask Mr. Fitzgerald questions when you were first bedside?

A Yes.

Q What questions did you ask him about his chest pain?

A Well, I can't tell exactly what I asked, but I can tell you what the answers were.

Q Fair enough. Let me try it this way. Did you ask him what he was doing when he first experienced chest pain?

A I don't recall what I asked him.

Q Is it your custom and practice to ask a patient what they were doing when they first

experienced chest pain?

A Typically, yes.

Q Can what a patient is doing at the time they first experience chest pain be relevant to diagnosis and treatment?

MS. WILLIAMS: Objection. Go ahead and answer.

A It may.

Q By way of example, seated, non-exertional chest pain versus activity chest pain, that can inform the treatment plan?

A It's information, yes.

Q Did you ask Mr. Fitzgerald to describe the character or nature of the chest pain?

MS. WILLIAMS: Objection.

A I don't recall what I asked him.

Q Are you familiar with describing character or nature of chest pain?

MS. WILLIAMS: Objection.

A I'm sorry, can you explain your question?

Q Sure. In your practice, have you ever asked a patient to describe the character of their chest pain?

A Yes.

Q When you do so, do you ever provide them with examples for them to pick from, so words to choose from, so to speak?

A I'll start with an open-ended question, and if they're confused, then I will offer them examples.

Q When you offer examples, what examples do you offer?

MS. WILLIAMS: Objection.

A I would offer -- typically would offer, "is it heavy, is it tightness, is it squeezing, does it feel like pressure or burning?" I usually ask about burning.

Q Can the character of a patient's chest pain be a piece of information useful to treatment and diagnosis?

A Yes, it may be.

Q Did you ask Mr. Fitzgerald whether his chest pain was constant, whether it waxed and waned? You tell me.

MS. WILLIAMS: Objection.

A I don't recall what I asked him.

Q Does the note provide any information about what he was asked?

MS. WILLIAMS: Objection.

MR. BOTTAR: What's the basis for the objection?

MS. WILLIAMS: He's already said he doesn't know what he asked. This is -- he already explained that this would be the answer given.

MR. BOTTAR: Agreed.

Q Can you extrapolate from the answers given the questions you asked?

A I would be guessing.

Q I don't want you to guess. When did he first experience chest pain, according your note?

A He states he has been having some chest tightness when going out into the cold air for the last few days.

Q When you treated him that day, did you distinguish a difference between his complaint of chest pain and his complaint of chest tightness?

A I don't know that I can answer that. I don't know what I was thinking at the exact time.

Q Did you ask him questions about passing out after intercourse?

MS. WILLIAMS: Objection.

A I don't recall what I asked him.

Q Does the note provide information about passing out after intercourse?

A Yes, it does. States --

MS. WILLIAMS: You answered the question.

THE WITNESS: Oh, sorry.

MS. WILLIAMS: That's okay.

Q Does the note provide any information about when he passed out after intercourse?

A Yes.

Q Was intercourse complete when he passed out, had he had an orgasm?

MS. WILLIAMS: Objection.

A I don't know.

Q Did you ask any questions about whether intercourse was strenuous?

MS. WILLIAMS: Objection.

A I don't recall what I asked him.

Q What is diaphoresis?

A Sweating.

Q When you were first bedside with Mr. Fitzgerald, was anyone else present other than you and him?

A I don't recall.

Q If someone else was present other than you and him, would you have recorded it in the record?

A I probably would have referred to that person if they had stated something.

Q Did you have a custom and practice in February of 2012 to write in the record if someone other than the patient was the source of information about the patient?

A Yes.

Q Do you see any entries like that in this record?

A Yes.

Q What does it say?

A His girlfriend states -- do you want me to continue that?

Q Sure.

A Okay. His girlfriend states: He was out for about 1.5 minutes. Do you want me to keep reading?

Q No, that's fine. Do you have a memory of any questions or conversation you had with his girlfriend when you were first bedside?

A No, I don't recall this interaction.

Q After speaking -- when speaking with the girlfriend, did you then confirm the information with the patient?

A I don't recall.

Q Would it have been your custom and practice to do so?

A Yes.

Q Does your note provide any information about whether you queried the patient about whether this was the first time he had experienced chest pain like this?

MS. WILLIAMS: Objection.

A I'll review the note. There is two comments about his chest tightness. Nothing specifically states chest pain, other than stating that when he passed out, he had no CP or short -- SOB.

Q Let me back you up to Page 2 of 9 of Exhibit 1.

A Okay.

Q Nine or ten lines down begins, "Patient complains of." Do you see that?

A Page 2 of 9?

Q Yes, sir.

A Yes, I see it.

Q Please review that paragraph to yourself.

A Okay. Okay.

Q Was this information in the patient's record when you were first bedside with Mr. Fitzgerald on the 6th?

A I'm thinking probably not, because it's documented 12:32, which is after my initial contact with him.

Q Who's RD? Who is Ryan Donahue?

A Donahue is a registered nurse in the Emergency Department.

Q Was it custom and practice in February of 2012 for the RN to take a history from the patient after the patient was first seen by the ED physician?

MS. WILLIAMS: Objection.

MS. HAYES: Objection to form.

A I can't speak to what the nurses do.

Q Was Mr. Donahue bedside with you when you were first bedside?

A I don't recall.

Q Would it have been your custom and practice to review the information in this field at

some point while Mr. Fitzgerald was a patient in the hospital on February 6th, 2012?

A Yes.

Q You would have known at some point that day that he had complaints of three days of chest pain, correct?

MS. WILLIAMS: Objection.

MR. BOTTAR: What's the basis of the objection?

MS. WILLIAMS: He said he doesn't have a specific recollection of this patient.

MR. BOTTAR: That doesn't mean he can't answer questions. It's in the chart. I'm asking what the chart says.

Q Would you have been aware of that information when you saw him that day at some point in time?

A At some point, yes.

Q Would you have been aware that he had complaints of moderate chest pain?

A What I would have been aware of is the history that I took and documented with the patient. Different people can reference the same thing

differently, so my role is to clarify that with the patient.

Q Fair enough. Did you clarify the information recorded by Mr. Donahue with Mr. Fitzgerald?

A According to my note, he didn't tell me chest pain. I documented chest tightness.

Q What is the first -- what are the last two words in the first sentence under your history of present illness?

A Patient complains of the complaint of chest pain.

Q Were those his words?

MS. WILLIAMS: Objection. Go ahead. You can answer it.

A That line usually comes from the chief complaint that they present in with, not his words.

Q Would it have been your custom and practice to follow up on information recorded by another healthcare provider in the patient's record about complaints of chest pain?

A I don't understand the question.

Q The information recorded by Mr. Donahue at 12:32 on February 6th, would it have been your

custom and practice to review that information, you to review it?

A Yes.

Q Would it have been your custom and practice to review that information with Mr. Fitzgerald at some point while he was in the Emergency Department?

A I do my H&P. That's when I communicate with the patient about signs and symptoms.

Q Slightly different question, though. Would you have reviewed what Mr. Donahue wrote with Mr. Fitzgerald at some point while he was in the Emergency Department?

A I may not have.

Q Did you place hands on the patient at some point, perform a physical examination?

A Yes, I did.

Q Was it a comprehensive physical exam, a problem-oriented exam? You tell me.

A Probably somewhere in-between. It was a generalized limited exam?

Q What do you mean by generalized limited exam?

A I'll do usually the heart, chest, abdomen,

musculoskeletal system, skin systems, and you know, make general references to the patient's alertness, mental status, neurologic stability with how he walks, moves his hands, speaks.

Q During that evaluation and specifically with regard to the cardiovascular system, would you use a stethoscope to listen to the heart?

A Yes.

Q Was it your custom and practice to check pulses, all four extremities?

A Yes.

Q Did you record any findings following your generalized limited exam in the record that are outside of normal limits?

A I'm sorry, did you ask if -- did I record anything?

Q Yes, sir.

A You mean anything abnormal?

Q Sure, anything abnormal.

A He had wheezing.

Q How did you -- withdrawn. Was the wheezing audible?

A I don't know if it was heard without a stethoscope.

Q Okay. What does bilateral wheezing mean to you, if anything, on this patient?

A It means I heard wheezing in both sides of his lungs, right and left.

Q Does the note provide any information about the location of the wheezing in terms of lobes?

A It just says wheezing bilaterally.

Q What are rhonchi?

A Rhonchi are sounds that are heard in the chest.

Q What can rhonchi be a sign and symptom of?

A It could be fluid rattling.

Q What does the word "absent" next to rhonchi mean to you, if anything?

A He had no rhonchi.

Q Following the history you took and the physical exam you performed, did you form a differential diagnosis for Mr. Fitzgerald's complaints that day?

A I'm sure I did.

Q Did you write a differential diagnosis in the record?

A I don't see that I documented differential

diagnosis prior to making my diagnosis.

Q What was your diagnosis?

A Syncope, vasovagal, dehydration, interactive airway disease, wheezing.

Q Before making your diagnosis, did you order any tests for Mr. Fitzgerald?

A Yes.

Q What tests did you order for Mr. Fitzgerald?

A I ordered an EKG, blood tests.

Q What blood tests did you order?

A I'm looking through the list now. Let's see. Cardiac troponin, troponin I, complete blood count with differential, comprehensive metabolic panel, and then the cardiac troponin is listed again, but we probably only did the one test. Magnesium and EKG.

Q Let me start with the CBC blood test. Why did you order a CBC?

A Looking for any signs of reactive component and anemia.

Q Did you order a CBC for any reasons other than the two you just gave us?

A I can't recall specifically what I was

thinking at the time.

Q Why did you order a comprehensive metabolic panel?

A Looking for general metabolic function in the body, electrolytes, kidney function. And the comprehensive panel also gives me a scan of the liver function.

Q Did you order a CMP for any other reasons?

A I don't recall any other. I don't recall what I was thinking at the time.

Q Why did you order a troponin I?

A Troponin I is looking for cardiac injury. It's released with cardiac injury, so I'm looking for any metabolic or chemical evidence of cardiac injury.

Q Did you order a troponin I for any other reason?

A I don't recall what I was thinking at the time.

Q Why did you order magnesium?

A Magnesium is ordered as part of our cardiac evaluation.

Q Why is that?

A Magnesium is a significant component in

muscle contractility in cardiac arrhythmias.

Q Did you order a test called creatinine kinase?

A Creatinine kinase?

Q Yes. Yes, sir.

A I don't see that that was separately ordered.

Q Have you ever ordered that test as part of a cardiac evaluation?

A Many years ago.

Q Do you -- withdrawn. Was the last time you ordered a CK many years ago?

A For a cardiac evaluation, yes.

Q What do you order now in lieu of or in place of CK?

A We're looking for muscle injury in somebody who may have been -- has significant muscle injury. Laying on the floor all night, as an example.

Q For the troponin I, do you have a general understanding of the results of a troponin test -- troponin I test?

A Do I know his results or do I understand the results of a troponin I?

Q Generally.

A Generally, yes.

Q Troponin is a protein of sorts?

A I think of troponin as a cardiac enzyme.

Q Do you have a general understanding of timing for release of the troponin cardiac enzyme following cardiac necrosis?

A Yes.

Q What's your general understanding of when that marker typically first presents hours after cardiac necrosis?

A Well, I mean, to be specific, you always have a troponin I number, but I think what you're asking is, is it elevated or abnormal.

Q Sure, whatever way you want to answer that.

A So typically anywheres from immediately to four hours is a typical timeframe that we see a troponin elevated after cardiac injury.

Q Are you aware of a typical time at which the cardiac troponin peaks hours after cardiac injury?

A Generally.

Q Okay. Is it roughly 24 hours after

cardiac injury?

A I think it's 12 to 24 hours. Everybody is a little bit different.

Q Fair enough. Different schools of thought.

A Right.

Q I appreciate that.

MS. WILLIAMS: Can I take a quick break?

(Whereupon, a short recess was taken.)

BY MR. BOTTAR: (Cont.)

Q Why did you order an EKG?

A Looking for cardiac arrhythmias or abnormalities.

Q Was a reason you ordered an EKG Mr. Fitzgerald's complaint of chest pain?

A Yes.

Q Were you made aware of the results of the labs you ordered?

A I looked at them.

Q Tell me generally how that works, and by way of example, are you provided a print copy, is there an alert on a computer screen? You tell me.

How do you know when --

A It's an electronic record, so I look on the computer screen.

Q Is there typically a field or a location where it provides or reports that a lab result is complete and been returned?

A In our current medical record, which was also used in 2012, I don't think there's an alert that's in there, but I check them regularly.

Q At that time was there any component of the St. Joe's electronic medical record that contacted you wirelessly in your phone to alert you about results?

A No.

Q Did you review the lab work as part of your prep for deposition today?

A Yes.

Q Let's start with the troponin. I've got some basic questions about that. What do you understand a point-of-care troponin to be and whether it's different than a draw troponin, what do you know about POC troponin?

A The tests today are very sensitive, so the point-of-care troponin is a rapid test.

Q Is it a fingerstick, so to speak?

A Well, they can get it from a blood tube or a fingerstick, yes. It could be a fingerstick. I don't think they do it that way at St. Joe's. I think they take it off the blood tube.

Q What time was the troponin result complete to report it out?

A It shows on the record here at 13:58.

Q Was there a nonfinal or preliminary troponin that you reviewed prior to 13:58?

A I don't recall.

Q Only if you know. This is the only one I have in the record, so if you have a separate memory, tell us.

A I don't.

Q What was the result of the troponin I?

A It was in the normal range.

Q Was there any troponin in Mr. Fitzgerald's system on February 6th?

A Yes.

Q What does .06 mean to you, if anything?

A It means it's in the normal range.

Q In your experience, do patients -- can patients without cardiac damage have a troponin that

is above zero?

A Yes.

Q What is the etiology of a troponin above zero without cardiac damage?

A That's not clear. We see it in renal failure patients frequently.

Q Was Mr. Fitzgerald in renal failure?

A I don't believe so.

Q Do you see it in other patients, so a troponin above zero in patients without cardiac damage?

A Yes.

Q What other patients?

A We see it pretty regularly whenever we test it.

Q It appears the result is 13:58. Either from your memory or review of records, when was the blood drawn?

A I'm not sure I can tell what time. Let me see. Collected -- blood collected at 13:25 and for the troponin it says 13:36.

Q Between the time that Mr. Fitzgerald presented to St. Joe's at around noon and 13:36, what was his troponin I result?

A 0.06.

Q Before you have that result, so for the first hour and a half or so he was at the hospital, what was his troponin?

A I don't know.

Q After 13:58 until discharge, what was his troponin?

A I don't know.

Q What are serial troponins?

A Those are troponins you do over time --

Q And --

A -- separated by hours.

Q How many hours typically for separation between troponins when ordering serial troponins?

A It depends on what you're looking for and who you are. It could be anywheres from two hours to six hours to twelve hours.

Q Have you ever ordered serial troponins?

A Yes.

Q Did you consider ordering serial troponins for Mr. Fitzgerald?

A No.

Q What was the significance, if any, to your diagnosis and treatment plan for Mr. Fitzgerald of

his .06 troponin result?

A I reviewed him for follow-up cardiac evaluation.

Q Is there an entry in the record that tells you, you referred him for cardiac evaluation?

A Not directly, that I can see.

Q Do you have a memory separate from the record?

A No. Cardiac evaluation is part of a syncope workup, so there's a referral for syncope that would have included cardiac evaluation in my mind.

Q Did you ever tell Mr. Fitzgerald on February 6th that in your mind you were referring him for a cardiac evaluation.

A I don't recall any interaction with him.

Q Were there any results outside of normal limits for the complete metabolic panel?

A Yes.

Q What results were outside normal limits?

A The glucose was listed as high at 100 and the calcium is listed as being low at 8.1.

Q Did those results inform your treatment plan for Mr. Fitzgerald --

A No.

Q -- on the 6th? Did you review the results of the CBC with diff?

A Yes.

Q By review, reviewed while he was in the ED on the 6th?

A I don't recall.

Q Would it have been your custom and practice?

A Yes.

Q Was he anemic on February 6th?

A He would not have been classified as being anemic.

Q How do you define anemic?

A Anemia is a significant drop in the hematocrit, or percentage of red blood cells.

Q Was the result for the red blood cells outside of normal limits?

A Outside of the reference lab's limits. It was listed as 40, yes, listed as being low.

Q Were the results for the hematocrit outside of normal limits?

A That was the hematocrit, 40, yes, as listed as low.

Q Is a patient with low hematocrit and low red blood cells anemic?

MS. WILLIAMS: Objection.

A I wouldn't consider 40 as being anemic.

Q Where is your threshold?

A Definitely down into the 30s I might consider anemia.

Q Did you consider anemia for Mr. Fitzgerald on February 6th?

A No.

Q Were you aware of an association between anemia and heart attack?

A Yes.

Q Do you know any of the statistics?

A No.

Q Did you discuss with Mr. Fitzgerald the results of his CBC on February 6th?

A I don't recall.

Q Did you tell him that patients with anemia are at 41 percent greater risk of heart attack than those without anemia?

A I don't recall my interaction with him.

Q Did the results of the CBC inform your treatment plan for Mr. Fitzgerald on February 6th?

A What do you mean by inform?

Q Did you take those results into consideration and provide any care or treatment to him based upon the results?

A I saw the results and found them to be inconsequential.

Q The result of the magnesium was within normal limits?

A I'm not seeing the results of magnesium in this paperwork. Here it is. I have it. 1.7, that was within normal limits.

Q We've gone through the labs. We can move quickly through the medicine orders. You prescribed DuoNeb.

A DuoNeb, yes.

Q What is that?

A It's a nebulized treatment of albuterol and Atrovent.

Q Why did you prescribe that?

A He had wheezing on exam. It suggested a bronchospasm, and these are bronchodilators and drying agents.

Q How was the DuoNeb administered to Mr. Fitzgerald?

A Well, I don't -- didn't see it given to him.

Q Does the record tell you whether it was given to him?

A Probably. So DuoNeb, one vial, was nebulized.

Q That's inhaled in some fashion with moisture, yes, nebulizer?

A Yes, little device makes the liquid in small droplets. It can be inhaled.

Q Did you assess or examine Mr. Fitzgerald after he received DuoNeb by a nebulizer?

A I don't recall the interaction.

Q Is there any information in the record that tells you one way or the other whether you were informed about the results, if any, of the DuoNeb administration?

A The respiratory therapist documented he tolerated it well, but I don't recall being told by the respiratory therapist anything.

Q You also prescribed saline, normal saline?

A Yes.

Q Did you prescribe albuterol?

A Yes.

Q Why did you prescribe albuterol?

A I believe that was an inhaler for him to go home with, because of his bronchospasm.

Q Was he administered albuterol in the Emergency Department?

A As part of the DuoNeb, he was.

Q You prescribed prednisone?

A Yes.

Q Why did you prescribe prednisone?

A As treatment for his reactive airway disease.

Q Did he receive prednisone in the Emergency Department?

A I'd have to see if there's a nurse's note. That was ordered.

Q Did you order it?

A Yes, I did.

Q Was your expectation that he would receive it if you ordered it?

A Yes.

Q Did you prescribe DuoNeb, albuterol, and prednisone for your presumptive diagnosis of reactive airway disease?

A Yes.

Q Did you prescribe those medications for any reason other than reactive airway?

A I don't recall my interaction or what I was thinking at the time.

Q Is that what you customarily prescribe those medications for?

A Yes.

Q Did you review the EKG tracing?

A Yes.

Q Did you review the unconfirmed EKG tracing?

A Yes.

Q Do you have a --

A What do you mean unconfirmed, by the cardiologist?

Q Yes, sir.

A Yes.

Q That's where I'm going next. Do you have a general understanding of the difference between an unconfirmed and a confirmed EKG tracing with reference to cardiology involvement?

A Yes.

Q What's your general understanding of the difference between unconfirmed and confirmed?

A Unconfirmed is a cardiologist has not looked at it and confirmed it. Confirmed is that they have.

Q Do you have a general understanding of what a cardiologist confirms when they confirm an EKG?

A My understanding is within 24 hours they typically will -- it's not always a cardiologist doing the confirmation, it's somebody who is certified to read EKGs, sometimes they're internists. Yes, they're looking at the EKG and writing what their reading is.

Q Was there a report generated for the EKG performed on the 6th?

A By cardiology?

Q Yes, sir.

A Yes, there was.

Q Does the report provide any information from a cardiologist about findings for the EKG?

A Yes.

Q What does it provide for findings?

A The cardiologist's opinion of the EKG.

Q Where is that recorded on the confirmed EKG?

A That would be up at the top, in the middle.

Q In the lines beneath 06 Feb 2012?

A Correct.

Q From your perspective, all four lines of the all-caps text?

A Yes.

Q What is sinus bradycardia with marked sinus arrhythmia?

A Sinus arrhythmia is a pattern you see just related to breathing, of no clinical significance. Sinus bradycardia means it's a sinus rhythm triggered through the process and it's slower than 60 beats a minute.

Q Was the EKG interpreted as outside of normal limits? Let me fix that. Was the EKG interpreted by a physician other than you as outside of normal limits?

A Yes.

Q Did you interpret the EKG before you had the confirmed copy?

A I probably never even saw the confirmed copy.

Q Fair enough. Do you agree with the

findings on the confirmed copy?

A Yes.

Q You have training in the interpretation of EKG tracings, correct?

A Yes.

Q You can identify the QPRST components of the test?

A PQRST, yes.

Q There you go. The copy that you reviewed, did you place any ink?

A Yes.

Q What did you place on the copy that you reviewed?

A My initials, JM, the time 13:30, and NAD.

Q What does NAD mean to you?

A No acute disease.

Q On the copy that you reviewed, was the text "sinus bradycardia with marked sinus arrhythmia" nonspecific ST- and T-waves abnormality abnormal ECG, was it on the copy that you signed?

A Yes.

Q Do you agree with that information?

A Yes.

Q Where did that information come from, if

you know?

A It's generated by the EKG computer.

Q What was the significance, if any, of the nonspecific ST- and T-wave abnormality?

A Well, I was aware of it.

Q What was the significance, if any, of it to you on February 6th, 2012?

A My reading of the EKG was there was no acute process here, so I read it as nonacute process.

Q Was it outside of normal limits?

A Yes.

Q Did you share that information with Mr. Fitzgerald on February 6th?

A I don't recall what I spoke to him about.

Q Can a nonspecific ST- and T-wave abnormality be a sign or symptom of symptomatic coronary artery disease?

A Yes.

Q Can nonspecific ST- and T-wave abnormalities be a sign or symptom of myocardial ischemia?

A Yes.

Q When Mr. Fitzgerald was in the Emergency

Department on February 6th, did you order a cardiology consult?

A No, I did not.

Q Did you request that a cardiologist interpret the results of the EKG while Mr. Fitzgerald was in the Emergency Department on February 6th?

A No.

Q On February 6th, 2012, did Mr. Fitzgerald have any cardiac risk factors in his history?

A Yes.

Q What were they?

A He's a male. Family history. I believe -- I would think his blood pressure was slightly high. I don't recall if he was a smoker or not. I would have to look in the record.

Q Did you discuss with Mr. Fitzgerald while he was in the Emergency Department his cardiac risk factors?

A I don't recall what I spoke to him about.

Q Do good and accepted standards of practice require you to discuss with Mr. Fitzgerald his cardiac risk factors while he was in the Emergency Department?

A I would have discussed with him the -- my thoughts on what his symptoms were that brought him there.

Q Slightly different question with respect to cardiac risk factors. Did good and accepted standards of practice require you to discuss with him his cardiac risk factors in the Emergency Department?

A I don't know what the answer to that question is.

Q Okay. What do good and accepted standards of practice require, if anything, while Mr. Fitzgerald was in the Emergency Department in terms of relaying information to him about the results of the tests and labs you ordered for him that day?

A Accepted standards would be to discuss with him the findings I have related to his presented complaint, which to me was chest tightness, syncope, shortness of breath with exertion, going in and out of cold weather, his bronchospasm, and his clinical finding of dehydration.

Q The clinical finding you reference for

dehydration, is that something that the labs told you?

A I don't recall specifically what triggered that. I'll look at the labs. No, it didn't come from the labs.

Q How do you diagnose dehydration clinically?

A Dry mouth, dry lips, skin turgor. If we do the testing, we can sometimes get orthostatic drop in blood pressure and orthostatic elevation in heart rate.

Q Are there findings recorded in the record consistent with clinical dehydration?

A Yes.

Q Okay. What --

A I'm sorry. Was that a history of a problem or a physical finding?

Q Physical finding. Clinical finding.

A No physical or clinical findings.

Q Is there information in there about dehydration in some regard?

A Yes.

Q Did it come from the patient?

A It came as part of my history of present

illness.

Q What was the -- withdrawn. You diagnosed Mr. Fitzgerald with syncope vasovagal, yes?

A Yes.

Q One of your diagnoses?

A Yes.

Q Did you have a differential for the syncope diagnosis?

A Yes.

Q What was your differential?

A My differential for all syncopes would be cardiac event, dehydration, pain triggering the vasovagal response.

Q Did you rule out a cardiac event as a potential etiology for the syncope?

A Not completely.

Q What time was Mr. Fitzgerald discharged from St. Joe's?

A I don't see a nurse's note that shows what time they actually discharged the patient. It shows when the discharge instructions were printed out.

Q What time were the discharge instructions printed?

A 15:47.

Q Does discharge typically follow printing the discharge instructions?

A Yes.

Q After your first bedside with Mr. Fitzgerald on the 6th and prior to discharge, did you see him again?

A I don't recall.

Q Did you evaluate him as part of the creation of the discharge instructions?

A I don't recall my interaction with him.

Q Who chose or selected the discharge instructions for Mr. Fitzgerald?

A I did.

Q And how do you do that generally, is there a computer with drop-downs --

A Yes.

Q -- or a search box? You tell me.

A On the computer, we go to disposition and I pick admit or discharge, and then I put in the diagnoses, and then those diagnoses will give up a list of choices for discharge instructions based on those diagnoses, or I can call them up specifically, and then I click on those, and that's entered into the record.

Q At the time of discharge, did Mr. Fitzgerald report any improvement in his chest tightness following the treatments administered?

A I don't recall my interaction with him.

Q Did Mr. Fitzgerald have chest pain at the time of discharge?

A I don't recall my interaction with him.

Q Can you tell from the notes?

A Progress note at 15:43, patient is feeling much better -- much better after 20 liters of normal saline, breathing easier after the DuoNeb, and then discharge patient with MDI spacer and prednisone, directed to drink lots of fluids. Discuss with him effect of caffeine, which can be a dehydrating drink. So that progress note indicates that I did speak with him and re-evaluate him before discharge.

Q Other than what is recorded, do you have a memory of your interaction with Mr. Fitzgerald at or about the time of discharge?

A No.

Q Did you consider admitting Mr. Fitzgerald to the hospital for surveilance?

A I don't recall what I considered.

Q Did you consider ordering a stress echo

for Mr. Fitzgerald prior to discharge?

A No, not from the Emergency Department.

Q What is the Westside clinic?

A It's a St. Joe's clinic. It's a doctors' office.

Q Did you refer Mr. Fitzgerald to the Westside clinic?

A I believe I did.

Q Separate from the record, do you have a memory of referring him?

A I do not.

Q Was he a patient of the Westside clinic prior to February 6th, 2012?

A I don't think he was.

Q Why did you select the Westside clinic for him?

A We have two -- at that time we had two primary care offices that accepted ED follow-up visits, and they agreed -- they have agreed to see patients we refer to them within two to three days, and Westside was one of those.

Q Was Mr. Fitzgerald given anything in print at the end of his February 6th?

MS. WILLIAMS: Objection. Go ahead

and answer.

Q Was he given any papers?

A I didn't witness that.

Q Did you give him any papers?

A I did not.

Q In the record there are a couple of pages, I think three, that follow the nine pages of treatment notes, they say, "SJH ED Summary" at the bottom.

A Uh-huh.

Q If I could get you there.

A Okay.

Q Do you have those three?

A Yes.

Q About a third of the way down, it provides, "This note is to communicate information regarding your patient's visit to St. Joe's Hospital Health Center Emergency Department." My question for you is, was this transmitted to someone somewhere?

MS. WILLIAMS: Objection.

MS. HAYES: Objection. Form.

A I'm not part of that process. I can't say that it was or was not.

Q Did you participate in the creation of these three pages?

A This looks like it's an automatic computerized summary of the visit.

Q What does that mean to you, if anything, about whether you participated in the information on these three pages?

A Well, it took the information that I obtained from my history and physical and incorporated -- and imported it into this particular document.

Q Can we agree that the information you obtained in your history and physical is different than the information that Mr. Donahue obtained in his history from Mr. Fitzgerald?

A The verbiage is different. I don't know that the information is different.

Q Does your note provide any information about the duration of Mr. Fitzgerald's complaint of chest pain?

A My note doesn't document that he complained to me of chest pain. It documents he has chief complaint of chest pain. And when I clarified what that meant with him, he called it chest

tightness to me. That's the difference.

Q The words chest tightness, did you use quotes around those in your notes?

A I don't see any quotes in my notes.

Q The use of the word chest tightness was a decision that you made following your conversation with Mr. Fitzgerald?

MS. WILLIAMS: Objection.

Q You can answer.

A Yes.

Q Use of those words, was it in a simulation or digestion of information that he gave to you?

MS. WILLIAMS: Objection. Go ahead and answer.

THE WITNESS: I'm sorry?

MS. WILLIAMS: Go ahead and answer.

A Yeah, part of my responsibility is to clarify what patient's complaints mean.

Q After February 6th -- after discharge on February 6th, did you have any additional contact with Mr. Fitzgerald?

A Not to my knowledge.

Q Did anyone contact you and discuss Mr. Fitzgerald after February 6th, 2012?

A Not to my knowledge.

Q At some point in time, did you become aware of his death?

A Yes.

Q How did you learn of his death?

A I don't recall specifically. I think I may have been notified by my insurer.

Q Did you discuss Mr. Fitzgerald in any way with anyone performing the autopsy?

A No.

MR. BOTTAR: That's all I have. Thank you.

MS. HAYES: I have nothing.

MR. LARABY: I have no questions.

MS. LANGAN: I have nothing.

(Whereupon, the proceedings concluded at 11:48 a.m.)

C E R T I F I C A T I O N

I, Annette S. Potter, a Certified Court Reporter and Notary Public in and for the State of New York, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and after having been duly sworn by me, according to law, was examined by counsel.

I further certify that the examination was recorded stenographically by me and this transcript is a true and accurate record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand and notarial seal this 7th day of April, 2016.

Annette S. Potter

Annette S. Potter
Court Reporter